2016 Williamson County Medical Coverage

Medical Plan Enrollment and Change Form

Employee Name_____ **SSN#**_____ **Employee Date of Birth**_____

Address_____**City**_____**State**_____**Zip**_____

Best Contact Number (____)_____**E-mail** _____

Is your spouse a Board of Education or County Government Employee? Yes____ No____ If yes, name of your Spouse_____

Do you or your dependents have other coverage? Yes_____ No_____ **If yes, please provide a copy of insurance card for any participants that have other coverage available at time of enrollment.**

ARE YOU ENROLLING DUE TO :

_____ New Hire Enrollment (OR)

_____ Life Changing Event **If enrollment is due to Life Changing Event, please provide information in box below.**

Life Changing Event Date_____

Type of Life Changing Event: Add Dependent (s) or Terminate Dependent(s)

Birth/Adoption Marriage Divorce Death

Loss of Coverage Gained Coverage Court Order Other_____

Enrollment Due to a life changing event requires proof validating the event

ENROLLMENT ELECTION (check one)

*Option 1 Deductible Plan w/ Health Savings Account

_____ Individual Enrollment **_____ Employee + 1 Enrollment** **_____ Family Enrollment**

If you are enrolling in Option 1, **YOU MUST** set up your bank account as part of the enrollment process. Please follow the below URL link and use the enrollment ID provided for the online banking application for your H.S.A. through JP Morgan & Chase.

(The Benefits Department is NOT responsible for completing this step).

https://preenroll.healthcare.cigna.com/healthcare/preenroll/app/bank/welcome.do

Enrollment ID : **WilliamsonHSA**

Choose the annual amount you would like to have withheld from your salary and placed into your H.S.A. account for eligible health care expenses. Your 2016 election may be $0 to $2,850 for individual coverage or $0 to $5,750 for Employee +1 or Family coverage. Any contribution made from the county, including funds from the H.R.A./Screening, will need to be subtracted from you individual or family maximums.

ANNUAL Amount elected: **$**_____

(Once chosen, cannot be changed until next enrollment period)

Annual amount elected will be divided by the number of pay periods remaining in the plan year (Jan 1 – Dec 31) by the benefits department.

*Option 2 Deductible Medical Plan

_____ Individual Enrollment **_____ Employee + 1 Enrollment** **_____ Family Enrollment**

* I decline Medical Coverage _____

LIST ALL FAMILY MEMBERS TO BE ENROLLED OR TERMINATED

First, M.I., Last Name	Sex	Enrollment Election	Social Security Number	Date of Birth	Does Member have other Coverage?
Spouse*	M F	Add Term	- -	/ /	Yes No
Child**	M F	Add Term	- -	/ /	Yes No
Child**	M F	Add Term	- -	/ /	Yes No
Child**	M F	Add Term	- -	/ /	Yes No
Child**	M F	Add Term	- -	/ /	Yes No

***Enrollment of a spouse**: Spousal form must accompany this enrollment form. ****Enrollment of a child**: Copy of child's birth certificate must accompany this enrollment form.

By signing below, I agree to all terms and conditions of enrolling in and continued enrollment in the Williamson County Medical program, as such exist on the date of my enrollment as reflected below, and as such may change from time to time, with or without notice to me. I further represent and warrant that all information given by me is accurate, current and complete to the best of my knowledge. I agree to allow the Williamson County Benefits Department to have the appropriate deductions taken from my paycheck according to my above enrollment options.

Employee Signature: _____**Date:** _____